State of California—Health and Human Services Agency

Department of Health Services
WIC Supplemental Nutrition Branch

WIC PEDIATRIC REFERRAL

Health Care Provider:

Please provide the information requested below for your patient. This information will be used by our Program staff to assess your patient's health status and to provide nutritional counseling. An incomplete referral may delay Program benefits to your patient. A completed referral does not guarantee WIC Program benefits since Program eligibility requirements must be met. **PLEASE NOTE:** WIC provides iron-fortified concentrated liquid and powdered formulas ONLY.

Patient's name (last, first)	WIC identification number	Birth date	Sex ❒ Male ❒ Female
Parent/guardian name	Address (street, city, ZIP code)		Phone number

CURRENT	**CURRENT** (For patients 9 months or older)	**BIRTH DATA** (For patients under 12 months)	**BLOOD LEAD TEST**		
Length/height _____ ins.	Hemoglobin _____ gm/dl *and/or*	Birthweight _____ lbs.		Date	µg/dL
Weight _____ lbs.	Hematocrit _____ %	Birthlength _____ ins.	12-month result		
_____/_____/_____ Measurement Date	_____/_____/_____ Blood Test Date	❒ Small for gestational age ❒ Preterm (less than 37 wks)	24-month result		

IF FORMULA WILL BE NECESSARY AFTER AGE 1 YEAR, REASON AND TYPE OF FORMULA MUST BE INDICATED:

Reason: _____

Type: _____

Estimated time needed: _____

PLEASE INDICATE ANY MEDICAL CONDITIONS AFFECTING THIS PATIENT:

❒ Food Allergies ❒ Congenital Anomalies ❒ Developmental Disabilities ❒ Severe Dental Problems ❒ Illness, Acute ❒ Illness, Chronic

❒ Other (specify): _____

PLEASE DESCRIBE ANY OF THE CONDITIONS INDICATED ABOVE. INCLUDE DATES WHEN APPLICABLE: _____

PLEASE LIST ANY CURRENT MEDICATIONS/SUPPLEMENTS PRESCRIBED: _____

LOCAL WIC AGENCY:	Name of Physician/Health Care Provider/Group/Clinic Phone Number:
	IMPORTANT: Must Be Signed by Health Care Provider

PM 247 A (1/01)

The USDA is an equal opportunity provider and employer.

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